Local Management Entities:

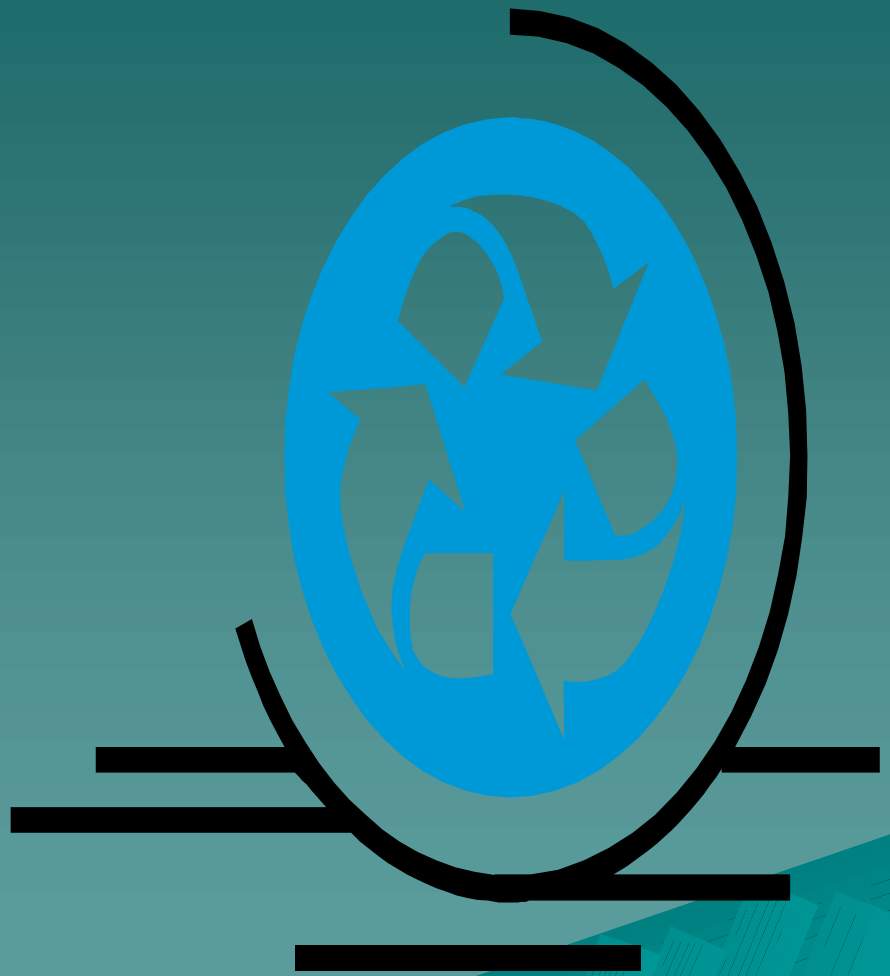
What Does the LME Do?

February 29, 2008

Mark O'Donnell

Agenda

- Mental Health Transformation Accomplishments: A Review
- CFAC responsibilities
- LME Functions/Responsibilities
- Performance Contract
- A CAP Thought
- Consumer Empowerment/LME Team



Goals of Transformation

Vision: NC residents with MH/DD/SA needs will have prompt access to evidence-based, culturally competent services in their communities to support them in achieving their life goals.

Guiding principles:

- Participant driven
- Community based
- Prevention focus
- Recovery outcome oriented
- Reflect best treatment/support practices
- Cost effective

ACCOMPLISHMENTS

- Implemented new rules for Child Residential Tx providers designed to improve the health and safety of children served in those facilities through increased staffing and increased staff qualifications.
- Allocated funding to support dedicated SOC liaisons in each LME to better coordinate services for children following SOC best practice model.
- Created the NC Practice Improvement Collaborative, a group of clinical leaders, research leaders and consumers and advocates, to evaluate new and promising services to ensure that NC offers the best possible array of services for individuals with mhddsas disorders.
- Funded six new halfway houses for adults recovering from SA disorders, bringing the total number in NC to 106, providing homes for nearly 800 people.
- Developed and implemented, in partnership with the NC Housing Finance Agency, a program of rental subsidies to assist individuals with disabilities in obtaining safe, decent and affordable housing. Expanded the program with support from the GA in 2006 to build and provide rental assistance for an additional 400 housing units.

ACCOMPLISHMENTS

- Permanently closed 539 state psychiatric hospital beds and transferred over $15.4 million in annual recurring savings from the hospitals' budgets to the community to pay for community services.
- Permanently closed 82 beds in the state developmental centers and transferred $4.1 million in Medicaid from centers' budgets to the CAP-MR/DD program to pay for community services.
- Created a redesigned EB Tx model for the ADATCs. Established 15 additional acute beds at the Blakely ADATC and opened 10 new beds at Keith ADATC.

ACCOMPLISHMENTS

- Finishing construction of a new state psychiatric hospital in Butner to replace aging facilities at Dix and JUH.
- Implemented a provider endorsement process to ensure that providers enrolling in the Medicaid program to serve individuals with MHDDSAS needs meet minimum quality requirements.
- Created a cultural and Linguistic Competency Advisory Committee to recommend strategies to ensure that services meet the needs of varied populations within NC. Adopted and published a related Action Plan.
- Jointly conducted with DFS licensure reviews in 1,054 CA residential facilities. These reviews found that 305 facilities were vacant and that 83 of the vacant facilities had never served any clients. 458 facilities had standard deficiencies, 71 had administrative sanctions and 105 surrendered their license to operate. As of December 2006, there were 635 licensed facilities.

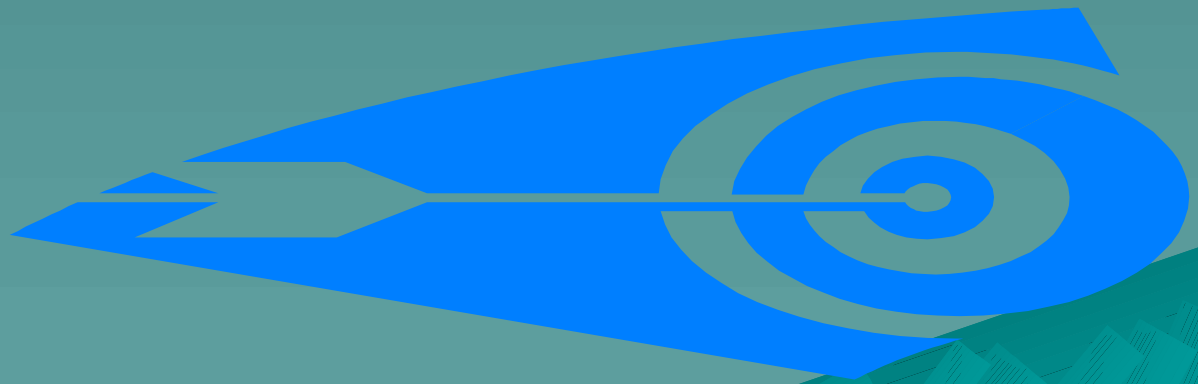
"Part 4A. Consumer and Family Advisory Committees.
"§ 122C-170. Local Consumer and Family Advisory Committees.

- (a) **Area authorities and county programs shall establish committees made up of consumers and family members to be known as Consumer and Family Advisory Committees (CFACS)**. A local CFAC shall be a self-governing and a self-directed organization that **advises** the area authority or county program in its catchment area **on the planning and management** of the local public mental health, developmental disabilities, and substance abuse services system.
- Each CFAC shall adopt bylaws to govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters. At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.
- (b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than two consecutive terms. The CFAC shall be composed exclusively of:
- (1) Adult consumers of mental health, developmental disabilities, and substance abuse services.
- (2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.
- (c) The CFAC shall undertake all of the following:
- (1) Review, comment on, and monitor the implementation of the local business plan.
- (2) Identify service gaps and underserved populations.
- (3) Make recommendations regarding the service array and monitor the development of additional services.
- (4) Review and comment on the area authority or county program budget.
- (5) Participate in all quality improvement measures and performance indicators.
- (6) Submit to the State Consumer and Family Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
- (d) **The director of the area authority or county program shall provide sufficient staff to assist the CFAC in implementing its duties** under subsection (c) of this section. **The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on business plans and budgets, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.**

LME

Functions and Responsibilities

As defined in the Local Business Plan and the Performance Contract



LME Business Plan Relationship

Relationship:

- **The LME Business Plan represents the scope of work of the contract between the Department of Health and Human Services hereafter referred to as the "Purchaser" (of administrative functions) and the local management entities (LMEs).**

- **The LME as a contractor has an obligation to ensure sufficient transparency to support the ongoing verification by the Purchaser of the organization's adherence to the Plan.**

LME Business Plan Functions

The plan was divided into six (6) chapters that correspond to administrative units common to many LMEs:

1. **Governance / Administration,**
2. **Provider Relations / Development,**
3. **Service Management,**
4. **Quality Management,**
5. **Customer Service / Consumer Affairs**
6. **Business Management / Information**

LME Business Plan Elements

Each LBP chapter addressed the common elements of:

- **Mission,**
- **Purchaser Standards,**
- **Current Operations,**
- **Strategic Objective,**
- **Resource Allocation, and**
- **Business Rules**

LME Business Plan Elements

Mission: A mission statement is about what the LME strives to accomplish.

Purchaser Standards: Purchaser has identified a number of the *requirements, Policies, Statutes and Rules* that apply to a function. Standards are listed as a reference for the LME to use when completing the LME/BP. For every standard listed, the LME shall indicate how that standard will be addressed in the LBP. Standards are listed as a reference to use when completing the LBP, but are not to be an exhaustive list (that the LME may add to).

LME Business Plan Elements

Current Operations: Current operations addresses how the LME has organized itself to fulfill all activities within the function An LME organizational chart is required for each discrete function to capture staffing patterns/FTEs.

Strategic Objective: The Strategic Objective comprises a narrative identifying the planned improvements in operations in each of the next three years.

LME Business Plan Elements

Resource Allocation: Resource Allocation compares the current operational costs of the LME with the cost model and requests an explanation for any significant (10%) deviation from that norm.

Business Rules: List up to six business rules (for each specific function) which proactively enhance and/or inhibit the efficiency and effectiveness of your organization.

Cost Model Reference

CONSUMER AFFAIRS

Consumer Affairs includes components of customer service and consumer rights. LME customer service offices are to respond to complaints, concerns, information requests and to aid the consumer/legally responsible person in navigating the system. LMEs are responsible for promoting public information about services and consumer rights, supporting local disability interest groups, human rights committees and Consumer Family Advisory Committees and conducting rights investigations. Consumer Affairs should ensure that community-based systems remain compliant with rights protections for recipients of supports and services. This function is also dedicated to promoting an open and consumer-centered culture within the LME.

MISSION: The LME shall include a mission statement regarding the operation of Consumer Affairs insuring compliance to the Performance Contract.

PURCHASER STANDARDS: Per the *Proposed Revisions for July 2006 Implementation To Attachment III: System Performance Draft 5-30-06.*

Interagency Collaboration: System of Care
Consumer Satisfaction: Timeliness of Care

CURRENT OPERATIONS: Describe how the specific activities and responsibilities within the Consumer Affairs function are currently implemented in your organization.

STRATEGIC OBJECTIVE: Identify areas of improvement needed within Consumer Affairs, stated in measurable terms, with target dates/timelines for completion, and the responsible person(s) within the organization. List the stake holder groups to be involved in the planning process.

RESOURCE ALLOCATION: Describe how the current resource allocation supports the Consumer Affairs functions.

Identify the current FTEs assigned to perform the Consumer Affairs function.

Provide information regarding the cost of performing the Consumer Affairs function and if the cost is more than a 10% variance from the cost model allocation provide a rationale/justification.

Identify any other operational variations from the assumptions in the cost model and provide a rationale/justification.

BUSINESS RULES: List up to five (5) of the most significant business rules (Rules, Statutes, Regulations, local policies, folklore) which inhibit the efficient and effective operation of the Consumer Affairs function.

Describe how operations would be different if there were effective changes to the three identified business rules.

Support To Committees	Appeals and Grievances	System Navigation	Customer Services and Rights	Consumer Satisfaction
Support of CFAC -Educate and communicate with CFAC regarding EBP and clinical practice standards.	**Respond to Complaints from consumers and family members of providers in catchment area per 10NC27G.0606. Identify staff to oversee all complaints and the Non-Medicaid appeal system per (DMH/DD/SAS Bulletin #38 and 10A NCAC 27I.0601-.0609). Includes complaint follow-up, rights investigations, monitoring and data collection and reporting requirements to ensure health, safety and quality improvement.**	**Assist consumers to "navigate" the system, including providing information on which providers are implementing evidence-based practices and on other public agencies/services.**	**Education and outreach to consumers and all stakeholders on: rights protections, complaint processes, advocacy and empowerment opportunities, evidence-based practices and service authorization guidelines.**	**Administer surveys to assess consumer knowledge/satisfaction with the process and with the support they receive.**
CFAC Travel.	**Engage in arbitration with consumers and providers.**		**Consumer outreach efforts for informational and educational purposes.**	**Mystery shopper (timeliness of service, provider choice).**
CFAC Training -Education on clinical practice standards. Understanding how to read aggregate data reports, Quality Management, Service System Issues, New Models of Services, Business and Strategic Planning 101, etc.			**Consumer education regarding state funded services authorization guidelines and evidence-based practices.**	
Staff support to committees: -CFAC -Clients Rights (10A NCAC 27G.0504 and G.S. 122C-170).			Provide staff support to encourage and develop consumer-run businesses, system of care, recovery orientation, knowledge about evidence-based practices, self-determination and peer support initiatives.	

THE STATE **WILL NOT** PURCHASE THE FOLLOWING ACTIVITES AS LME FUNCTIONS:

LME Function of Governance	LME Function of Business Management	LME Function of Claims Payment	LME Function of IT	LME Function of Provider Relations	LME Function of Access / STR	LME Function of Service Mgmt
Lobbying		Costs associated with the LME providing billing functions on behalf of providers eligible for direct enrollment	Development of systems and reports needed by LME as a service provider	Monitoring that duplicates monitoring by state and federal agencies	Provision of emergency services	100% review of Medicaid-only PCPs
Legal fees associated with disputes with any State agency	Cost reporting required by the LME as a service provider	Costs associated with the LME billing for services to Medicaid, Medicare, insurance,1st party, etc. for services its provides as a service provider		Cost of maintaining physical plants owned by the LME or county and used by service providers	Clinical assessments	Case management
Accreditation cost associated with LME as a service provider	Training of staff related to service delivery activities			Providing training to providers required by service definitions		Medical records cost for the LME as a service provider
Other administrative costs - including salary/benefit costs, rent, utilities, etc. - associated with LME as a service provider.	Other costs allocable to the LME as a service provider					
Marketing of LME services as a service provider						

DMH/DD/SAS Contract with Local Management Entities

2007-2010

2007-2010 Performance Contract

- This agreement is the result of the cooperative work of DMH and DMA
- Certain functions delegated to the LME pursuant to this Contract are the duty and responsibility of DHHS as the single state agency responsible for the administration of the North Carolina Medicaid program and as the grantee of federal block grant funds such as the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant and the Social Services Block Grant. The parties understand and agree that nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Secretary of DHHS to perform any of the duties assigned to the DHHS or its Secretary by the North Carolina General Statutes, the State Medicaid Plan, the Medicaid laws and regulations, the terms and conditions of the block grants and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by DHHS to reimburse the LME for any of its contractual duties

WHY a Performance Contract?

- Contract
  - Provides specific expectations
    - For State
    - For LMEs
    - To Consumers/Families
    - To Providers
  - Establishes a business relationship
  - Establishes a mechanism for measuring success/ Ensuring that what is purchased is what is delivered

2007-2010 Performance Contract DHHS Responsibilities

- Certify the Local Business Plan
- Reimburse the LME for identified functions
- Monitor the LME for compliance
- Notify LME in a timely manner of changes as they occur
- Administer the Medicaid fair hearing process
- Collaborate with the LME on QM activities
- Share Medicaid paid claims and authorization data
- Establish procedures for fund transmission to LMEs

2007-2010 Performance Contract LME Responsibilities

- Serve as LME for MH/DD/SAS services in specific geographic area
- Update and implement LBP
- Perform functions
- Maintain adequate professional and other personnel
- Prioritize and manage State and non-Medicaid funds
- Adhere to statutory reporting and other requirements
- Monitor subgrantees
- Allow DHHS unrestricted access to all meetings, activities and documents re: functions per contract
- Contract with any Medicaid provider agency for billing purposes when said entity cannot directly enroll with DMA
- Implement LME crisis plan
- Seek national accreditation
- Achieve accreditation for waivered services LME provides

2007-2010 Performance Contract as regards Consumers and Families

Key Contract Elements with Consumer and Family Implications:

- **ATTACHMENT I**

SCOPE OF WORK

- **1.3 Consumer and Family Advisory Committee (CFAC) Meetings**
- The LME shall provide sufficient financial and administrative support to ensure that the CFAC shall meet the composition requirements of G.S. § 122C-170 and shall meet at least six (6) times per year. The LME shall provide sufficient training on the LME business plan, budget, and other topics to support the CFAC's review of regular reports on finances, local performance, and customer service on a regular basis. Unless delineated elsewhere, each LME shall define training needs.

2007-2010 Performance Contract

Key Contract Elements with Consumer and Family Implications:

- **5.0 Provider Relations and Support**
- **5.1 Assessment of Adequacy of the Provider Community**

The LME shall assess community need and provider capacity on an annual basis (during the third quarter of the contract) and update on a quarterly basis. The assessment shall take into consideration the population in the catchment area, identified gaps in the service array, and the number and variety of providers for each service. The assessment shall include input from consumers, families, and community stakeholders. In evaluating the adequacy of the provider community the LME shall consider issues such as the cultural and linguistic competency of existing providers. The assessment shall also measure the availability of providers willing to participate in community emergency response efforts, such as providing services in temporary housing shelters in the event of a natural disaster which triggers an evacuation. The LME shall report the results of the annual assessment and quarterly updates to the Board and CFAC. The LME shall demonstrate that it is engaged in development efforts to address service gaps identified in the assessment.

In addition, the LME shall assess community need and provider capacity for children's services within the LME catchment area. The LME shall contract with a sufficient number of service providers to ensure that children receive services in settings which are more likely to maintain or develop positive family and community connections.

5.2 Choice of Providers

The LME shall ensure that consumers eligible for Medicaid will have freedom of choice of providers. For State services, consumers will have a choice of at least two providers for every service, except for those services with very limited usage.

2007-2010 Performance Contract

Key Contract Elements with Consumer and Family Implications:

6.1 Telephonic Access

The LME shall provide toll free access lines to its entire catchment area. The toll free telephone number shall be widely disseminated throughout the catchment area through written and broadcast public service announcements, and by including the number prominently in all LME publications and on the LME website.

6.3 Triage and Referral

The LME shall refer consumers to the providers of their choice, subject to the following access standards:

(1) Consumers experiencing an emergency are able to access emergency services through the LME and receive face to face services within two hours of the request for service.

(2) If the consumer need does not constitute an emergent (immediate) situation, but is nonetheless urgent (an urgent need is a consumer who presents moderate risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to mh/dd/sa problems) rather than routine, the LME shall refer consumers to a provider capable of delivering face-to-face services within 48 hours of the request for services;

(3) The LME shall refer consumers with a routine need (a routine consumer presents with mild risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to mh/dd/sa problems) for service to a provider capable of delivering face-to-face services within 10 working (14 calendar) days of the request for services

7.1.5 Consumer Notification of LME Service Authorization Decisions

The LME shall notify consumers when services are denied, reduced or terminated by the LME. This notification shall be in accordance with DHHS processes and procedures and shall advise the consumer of how to exercise their appeal rights regarding the decision.

2007-2010 Performance Contract

Key Contract Elements with Consumer and Family Implications:

7.2 Care Coordination

7.2.1 Care Coordination for Consumers without a Clinical Home

The LME shall provide care coordination services for consumers who are being discharged from state facilities, hospitals, or emergency services that do not have a connection with a clinical home provider. This includes participating in discharge planning and continuing to work with the consumer and primary care physician until the consumer is connected to a clinical home provider. The LME has the responsibility to ensure that staff is available for participation at the annual Plan of Care meetings for consumers from their catchment area who reside in a Developmental Center and are appropriate for community placement. The LME shall ensure that consumers who are being discharged from state facilities are seen by a community provider within 7 calendar days of discharge. The LME shall ensure that consumers who do not attend

scheduled appointments are contacted to reschedule services within 5 calendar days.

7.2.2 Care Coordination for High Cost/High Risk Consumers

The LME shall identify and provide care coordination services for consumers having high cost and/or high need. As defined in GS §122C-115.4 (1),(2), "the definition of a high risk consumer: until such time as the Commission adopts a rule, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months. The definition of a high cost consumer: until such time as the Commission adopts a rule, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group." This includes participating in Person Centered Planning, facilitating appropriate connections to primary health care services through Community Care, the Health Department, or other physical

Healthcare

7.3.5 Development of Housing Opportunities for Consumers

The LME shall work with public housing agencies and private landlords to increase housing opportunities for consumers. If the LME has a Division-funded housing coordinator position, the housing coordinator will work with the Division and DHHS housing staff to increase housing opportunities throughout the region to which the coordinator is assigned.

2007-2010 Performance Contract

Key Contract Elements with Consumer and Family Implications:

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8.0 Consumer Affairs and Customer Service

8.1 Supports to CFAC and the Human Rights Committee

The LME shall provide required competent, qualified staff and support to the CFAC and Human Rights Committees to fulfill the functions of these committees.

8.2 Consumer and Family Outreach and Education

The LME shall provide outreach, education and customer service to consumers and families on issues such as rights protection, complaint processes, advocacy and empowerment opportunities, evidence-based practices and service authorization guidelines. The LME shall publicize the priority for admission to a program for injection drug users and substance-abusing pregnant women.

8.3 Assistance to Consumers

The LME shall develop and maintain a Consumer Manual that assists consumers to understand the various parties in the public system, their roles and responsibilities. The LME shall provide assistance to consumers and families in understanding the public delivery system and other public agencies. The LME shall encourage consumer self-advocacy. The LME shall promote the growth of consumer owned and staffed businesses. The LME shall maintain, publish and staff a toll free customer service line during normal business hours.

8.4 Consumer Complaints and Appeals

The LME shall respond to complaints and process appeals from consumers in accordance with state rules and DHHS processes and procedures. The LME shall report all required information regarding critical incidents and consumer complaints and appeals to DHHS in the manner and timeframes outlined in policy and shall report aggregate information on incidents, complaints and appeals to the Board and CFAC quarterly. If a satisfactory outcome is not reached with the LME, the consumer may also appeal (122C-151.4) to the MH/DD/SA appeals Panel

2007-2010 Performance Contract

Key Contract Elements with Consumer and Family Implications:

Attachment II Performance Expectations

2.0 Summary of Functional Components

The DHHS will monitor the LME's implementation of each management function on an ongoing basis. A fully functioning LME shall have in place all of the components of each management function listed in the table below. The DHHS shall use the essential components (in bold) to evaluate the LME's performance of each function. The items in bold italics have implications for retention of Medicaid funding.

Function Components

General Administration and Governance

(1) Active Board that meets at least (6) times a year; (Attachment I 1.2)

(2) Active CFAC that meets at least six (6) times a year; (Attachment I, 1.3)

(3) **Qualified CEO that meets required qualifications per NCGS 122C-121(d); (Attachment I, 1.4)**

(4) Satisfaction of SPMP (FFP) requirements; (Attachment I, 1.5)

(5) ***Qualified clinical staff in all three disability areas (Attachment I, 1.5)***

2007-2010 Performance Contract

Key Contract Elements with Consumer and Family Implications:

Provider Relations

(1) Annual assessment of community need and provider capacity and quarterly updates reported to Board & CFAC; (Attachment I, 5.1)

(2) ***Minimum number of provider agencies for every service necessary to ensure consumer choice; (Attachment I, 5.2)***

(3) ***Process for timely endorsement and enforcement of endorsement requirements; (Attachment I, 5.4)***

(4) Appropriate provider manual, trainings and technical assistance;
(Attachment I, 5.3 & 5.6)

(5) ***Process for ongoing evaluation and monitoring of provider quality and compliance with data submission requirements; (Attachment I, 5.5)***

(6) Process for resolving provider complaints. (Attachment I, 5.7)

Access /Screening, Triage and Referral

(1) ***Toll-free phone line; (Attachment I, 6.1)***

(2) ***24-hour access 365 days a year; (Attachment I, 6.1)***

(3) ***Calls answered within 30 seconds by trained staff; (Attachment I, 6.1)***

(4) ***TTY and Relay capability and Spanish-language interpreter; (Attachment I, 6.1)***

(5) ***Ability to schedule appointments with an appropriate provider within 24 hours of initial contact; (Attachment I, 6.1)***

(6) Process for managing DHHS bed-day allocations; (Attachment I, 6.4)

(7) Report to Board and CFAC on access patterns and trends; (Attachment I, 1.2)

(8) Screening consumers using the standard state form or all of the elements of the standard from. (Attachment I, 6.2)

2007-2010 Performance Contract

- **Key Contract Elements with Consumer and Family Implications:**

Consumer Affairs and Customer Service
(1) **Customer service phone line answered during business hours by live staff; (Attachment I, 8.3)**
(2) Outreach/education activities and materials (English & Spanish); (Attachment I, 8.2)
(3) **Consumer Manual**; **(Attachment I, 8.3)**
(4) Timely response and resolution (disposition) to consumer questions and complaints; (Attachment I, 8.4)
(5) Staff support to the CFAC and Client Rights Committees; (Attachment I, 8.1)
(6) Report to Board and CFAC on consumer incidents, complaints, appeals, and satisfaction with services at least quarterly. (Attachment I, 1.2 & 8.4)

Quality Management
(1) **Timely identification and remediation of problems; (Attachment I, 9.1)**
(2) Production and review of regular management reports; (Attachment I, 9.2)
(3) **Collection and submission of consumer data; (Attachment I, 9.3)**
(4) **Analysis and use of data for planning, decision making and improvement; (Attachment I, 9.4)**
(5) Active Quality Improvement committee; (Attachment I, 9.4)
(6) Report on QI activities to Board and CFAC quarterly and to DHHS annually. (Attachment I, 1.2 & 9.4)

2007-2010 Performance Contract

- **Sample Goals:**

4.1.1 Adult Mental Health (AMH) Services
SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 38%
SFY 2008 Target: By June 30, 2008 the LME shall reach or exceed the percent of persons receiving AMH services at the most current annual state average of 38%.
Prevalence Estimate:
A national prevalence estimate for North Carolina is determined by the federal Center for Mental Health Services annually. The most recent statewide prevalence estimate (for FFY 2005) is that 5.4% of adults ages 18 and above have a serious mental illness in any given year.

4.1.2 Child/Adolescent Mental Health (CMH) Services
SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 38%
SFY 2008 Target: By June 30, 2008 the LME shall reach or exceed the percent of persons receiving CMH services at the most current annual state average of 38%.
Prevalence Estimate:
According to the most recent national prevalence estimate, as determined by the federal Center for Mental Health Services for FFY2005, 12% of children and adolescents ages 0-17 have a serious emotional disturbance in a given year. Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate will be applied to the LME's population ages 3-17.

CAP

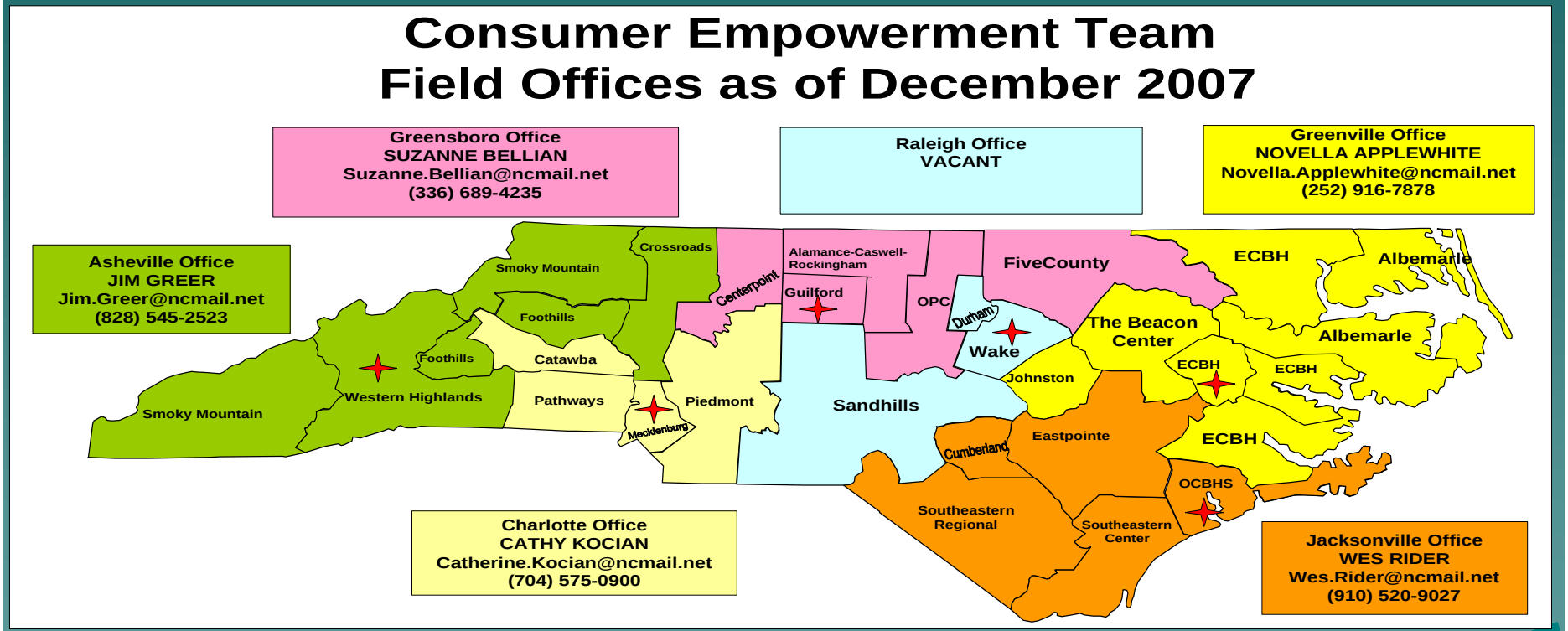
- In an effort to provide a method for stakeholders to provide thoughts, ideas and comments concerning the development of the tiered waivers, a special email account has been created. Please send any information you like to this email account: Tiered.Waivers.Development@ncmail.net

Questions?

For More Information

- Contact
  - your LME
  - your state CFAC Liaison
  - your state LME Liaison

Consumer Empowerment Team Field Offices as of July 2007



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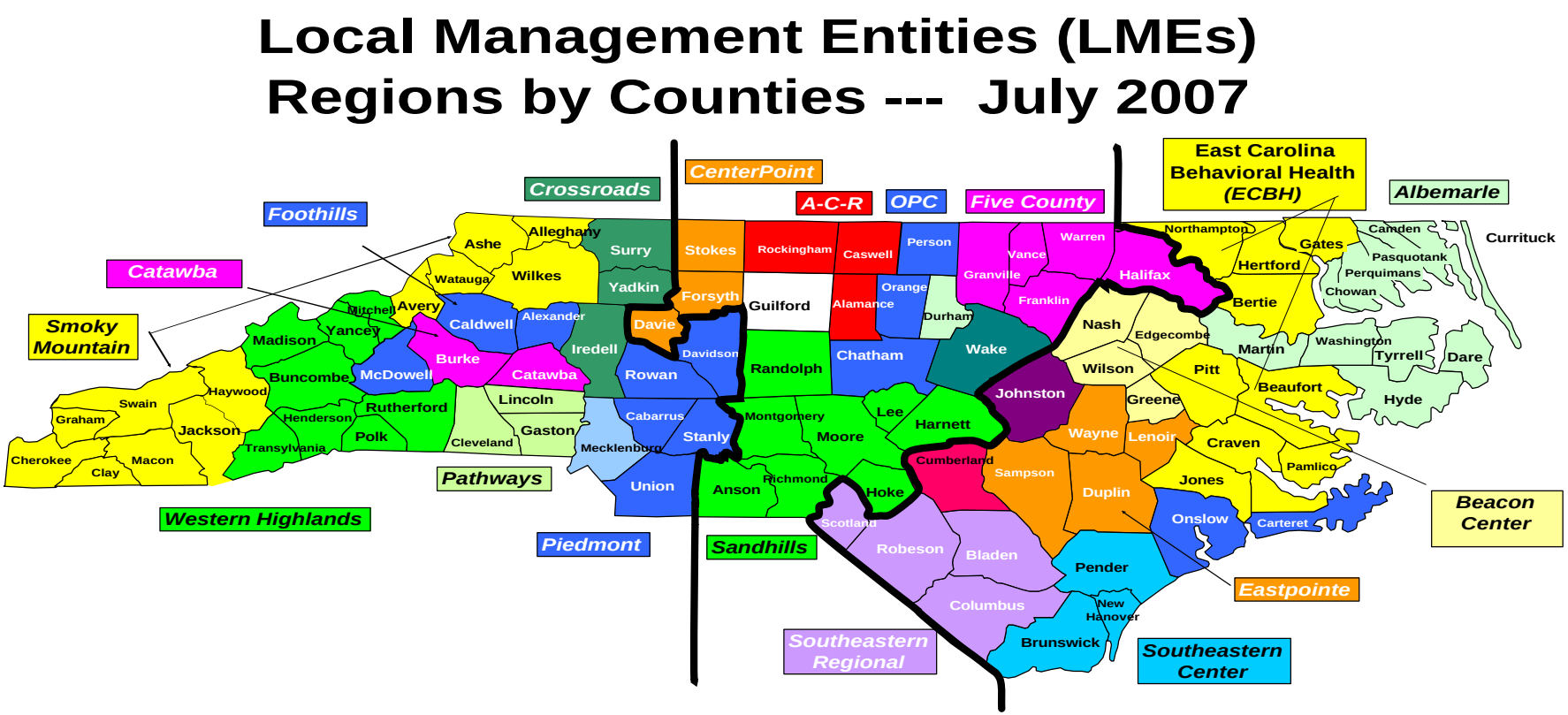
Local Management Entities (LMEs) Regions by Counties --- July 2007



The counties within an LME share the same color. Unless otherwise indicated, the LME name is the county name(s).

Dick Oliver, LME Team Leader (919) 715-1294

LME TEAM MEMBERS:

Western Region Team Members:		
Bill Bullington (828) 266-3632	Julia Sinclair (919) 715-1294	PBH assigned to Ken Marsh

Central Region Team Members:		
Mark O'Donnell (919) 218-7832	Ken Marsh (252) 492-6971	Yvonne French (919) 218-6892

Eastern Region Team Members:		
Rose Burnette (252) 355-9032	Marie Kelley (919) 218-5950	Mabel McGlothlen (919) 218-1953

"Knowledge speaks,

but wisdom listens."

- Jimi Hendrix